First Steps

Documentation Forms for Printing

August 2005

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(Adobe Document)

Forms for Printing

Business Forms - Samples

Chart # _____

CLIENT REGISTRATION

CLIENT INFORMATION

NAME: First /Middle/Last | Maiden Name:

Also Known As:

Street Address/City/State/Zip | Date of Birth:

Sex: ___ M ___ F

Address Change: date_____ | Home Phone: | Cell Phone:

Address Change: date_____ | Work Phone: | Email address:

Mailing Address: Address/City/State/ Zip Code

Marital Status:
☐ Single ☐ Married
☐ Widowed ☐ Divorced
☐ Unknown

Race: *(Check one or more*)
☐ White
☐ Black or African American
☐ American Indian* or Alaska Native
☐ Asian: Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian *(Specify):*

☐ Pacific Islander: or Native Hawaiian
- ☐ Samoan
- ☐ Guamanian or Chamorro
- ☐ Other Pacific Islander *(Specify):*

☐ Other *(Specify)*:

Ethnicity:
☐ Spanish/Hispanic/Latino
- ☐ Mexican, Mexican American, Chicano
- ☐ Puerto Rican
- ☐ Cuban
- ☐ Other Hispanic *(Specify):*
- ☐ Unknown

☐ Other *(If applicable):*

Primary Language: | *Tribal Affiliation: | Agency Use

Interpreter Needed: Yes: _____ No: _____ | Client Social Security # (*Agency option)*

If the client is a child, please complete the following:

Mother's Name: | Mother's Maiden Name: | Father's Name/Age:

Mother's Social Security # *(Agency option*): | Father's Social Security # *(Agency option):*

Mothers Address *(If different from patient):* | Father's Address *(If different from patient):*

City, State, Zip | City, State, Zip

May we contact you at your home address or phone number? ☐ **Yes** ☐ **No** *(If no, complete boxes to the right)* ⇨ May we identify ourselves? Yes ____ No ____ *(If no, code name _____)*	Alternate Address:	Alternate Phone(s):
	City, State Zip	

EMERGENCY CONTACT INFORMATION

Name(s):	Phone Number(s):

MEDICAID/INSURANCE INFORMATION: *Please present your insurance card or medical coupon to the receptionist.*

PIC # (If Medicaid/Healthy Options):	Insurance Company:
Effective Date:	Policy Number:
Infant's PIC#:	Policy Holder' Name *(If different from patient):*
Effective date:	Policy Holder's Social Security Number:
Patient's relationship to Policy Holder (*Mark one*): ☐ Self ☐ Spouse ☐ Child ☐ Guardian	

FINANCIAL AND INSURANCE CERTIFICATION

I certify the financial and insurance information given is accurate and current. If insurance or Medicaid information is invalid, I understand I will receive a bill for the full fee for service. I authorize my insurance benefits be paid directly to the provider. I also authorize the provider or insurance company to release any information required for payment of this claim.

Signature:_____ Date: _____

FAMILY INFORMATION *(Please list all of your family members living in your home.)*

FAMILY MEMBERS	RELATIONSHIP TO CLIENT	DATE OF BIRTH

FREEDOM OF CHOICE

The First Steps Maternity Support Services/Infant Case Management Program offers you health services while you are pregnant and for a time after the baby is born.

Services are available through *(your agency name)* or through another program of your choice. If you wish, please ask for a list of other First Steps providers.

What happens next:

1. A plan will be developed with you to assist you in having a healthy baby.
2. You may receive services from a nurse, a nutritionist, a behavioral health specialist, a community health worker, and/or an infant case manager.

____ Yes, I would like to receive Maternity Support Services through *(your agency name).*

____ Yes, I would like to receive Infant Case Management Services through *(your agency name).*

_____No, I do not wish to receive services through *(your agency name).*

Client Signature: _____Date: _____

MSS/ICM Service Tracking

Date of Service	Staff Initials	Today's # of 15-Minute units used*		Running Total of Units Used*	
		MSS	ICM	MSS	ICM

Office and Home Visits **are billable** in First Steps Program.

Telephone Calls and Case Conferences **are not billable** in First Steps Program.

** See billing instructions for specific information*

_____ _____

Client Name Date of Birth

MSS/ICM BILLING INFORMATION
FOR AGENCY BUSINESS OFFICE

Service provided by:_____
Staff Signature

Please ***PRINT COMPLETE LEGAL*** name:

Client:_____
Last First MI

PIC #_____
(*Always complete and update)*

Effective Dates: Beginning_____

PREV NAME or MOM (If Child)_____ Ending_____

DATE of BIRTH_____ Agency #_____

VISIT STATUS: _____First Visit this year _____First Visit _____Repeat Visit **LMP:** _____

Date of Service	**Place of Service**		**Procedure Code – Description**		**# of Units *(1 unit = 15 min)***
_____	Office		T1002-O	RN Services-Office	_____
_____	Home		T1002-H	RN Services-Home	_____
_____	Office		S9470-O	Nutritional Services - Office	_____
_____	Home		S9470-H	Nutritional Services – Home	_____
_____	Office		96152-O	Behavioral Health Services-Office	_____
_____	Home		96152-H	Behavioral Health Services -Home	_____
_____	Office		T1019-O	Community Health Worker-Office	_____
_____	Home		T1019-H	Community Health Worker-Home	_____
_____	H	O	T1023	Family Planning Performance Measure	1 x only
_____	H	O	S9075	Tobacco Cessation Performance Measure	1 x only

Dx Code: V22.2 Pregnant State, Incidental

_____	H	O	T1017	Targeted Infant Case Management	_____

Dx Code: V20.1 Health supervision of infant

Agency Specific _____

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Clinical Charting Forms - Samples

Signature Log

Agency: _____

Name *(Print)*: _____ Title *(RN, RD, etc)*: _____

Signature: _____ Initials: _____

Name *(Print)*: _____ Title *(RN, RD, etc)*: _____

Signature: _____ Initials: _____

Name *(Print)*: _____ Title *(RN, RD, etc)*: _____

Signature: _____ Initials: _____

Name *(Print)*: _____ Title *(RN, RD, etc)*: _____

Signature: _____ Initials: _____

Name *(Print)*: _____ Title *(RN, RD, etc)*: _____

Signature: _____ Initials: _____

Name *(Print)*: _____ Title *(RN, RD, etc)*: _____

Signature: _____ Initials: _____

Client Name: _____ Date of Birth: _____

CLIENT CONTACT LOG

Contact Type: OV = Office Visit HV = Home Visit TC = Telephone Call CC = Case Conference

Staff Discipline: RD = Registered Dietician CHN = Community Health Nurse
BHS = Behavioral Health Specialist CHW = Community Health Worker

DATE	CONTACT TYPE	STAFF	NOTES

First Steps Program: Office and Home Visits **are billable**.
Telephone Calls and Case Conferences **are not billable**.

See Billing Instructions for Specific Information

Client Name: _____ Date of Birth: _____

MSS/ICM CLIENT CONTACT LOG AND SERVICE TRACKING

Contact Type: OV = Office Visit HV = Home Visit TC = Telephone Call CC= Case Conference

Staff Discipline: RD = Registered Dietician CHN = Community Health Nurse
BHS = Behavioral Health Specialist CHW = Community Health Worker

DATE	CONTACT TYPE	STAFF	UNITS BILLED TODAY*	TOTAL UNITS BILLED	NOTES

FIRST STEPS PROGRAM: OFFICE AND HOME VISITS **ARE BILLABLE**
TELEPHONE CALLS AND CASE CONFERENCES **ARE NOT BILLABLE**

**SEE BILLING INSTRUCTIONS FOR SPECIFIC INFORMATION*

Client Name: _____ Date of Birth: _____

WELCOME TO MATERNITY SUPPORT SERVICES

Maternity Support Services (MSS) are preventive health services provided by a team including nurses, nutritionists, behavioral health specialists (counselors), and, in some agencies, community health workers. The main goal of MSS is to help you have a healthy pregnancy. You can receive Maternity Support Services during your pregnancy and through the end of the second month after your pregnancy is over.

PLEASE FILL OUT THIS QUESTIONNAIRE TO HELP US SERVE YOU BETTER

Your Name: _____ Your Birthdate: _____

1. Is this your first pregnancy? ☐ Yes ☐ No

2. Have you seen a doctor or midwife for your pregnancy? ☐ Yes ☐ No
   If yes, what is your doctor or midwife's name? _____

3. What date does your doctor or midwife say your baby is due? Date:_____ ☐ I am not sure.

4. Has your doctor/midwife said there are problems with your pregnancy? ☐ Yes ☐ No
   If yes, what are the problems? _____

BELOW ARE SOME OF THE THINGS MSS STAFF CAN HELP YOU WITH. TO HELP US MEET YOUR NEEDS. PLEASE CHECK THE BOXES THAT YOU WOULD LIKE TO KNOW MORE ABOUT OR HAVE HELP WITH.

In the areas of pregnancy, my health, prenatal care, getting ready for my baby, and the time right after my baby is born, I would like to know more about or have help with:

- ☐ Finding a doctor
- ☐ What to expect during doctor visits while I'm pregnant
- ☐ Body changes in pregnancy
- ☐ Dealing with discomforts in pregnancy
- ☐ Dangers in pregnancy
- ☐ Health problems I haven't talked to a doctor about
- ☐ How my health problems might affect my baby
- ☐ Problems with my teeth
- ☐ Quitting my tobacco use
- ☐ Asking people not to smoke in my home
- ☐ Getting into childbirth classes
- ☐ Breastfeeding
- ☐ Taking care of myself after my baby is born
- ☐ Birth control
- ☐ Taking care of my newborn baby
- ☐ Being a new parent
- ☐ Getting into classes for new parents
- ☐ Other:_____

In the areas of food, eating, and safe exercises I would like to know more about or have help with:

- ☐ Diet and weight gain
- ☐ Eating to help my baby grow
- ☐ Simple Exercises
- ☐ Menu Planning
- ☐ Other _____

In the areas of feelings, relationships, and coping with stress, I would like to know more about or have help with:

- ☐ Mood changes in pregnancy
- ☐ Dealing with past problems
- ☐ My feelings about past losses in my life
- ☐ Feeling scared or nervous about being a parent
- ☐ Getting along with my partner, or other people in my life
- ☐ Depression
- ☐ Anger
- ☐ Making new friends
- ☐ Dealing with stress
- ☐ Violence or fighting in my home
- ☐ Alcohol or drug use
- ☐ Having someone to talk with about my worries
- ☐ Other _____

In the area of other basic needs, I would like to know more about or have help with:

- ☐ Where to get clothing
- ☐ Where to get food
- ☐ Getting rides to the doctor or other important places
- ☐ Finding a better place to live
- ☐ Finding childcare
- ☐ Finding a doctor for my baby
- ☐ Finding a school
- ☐ Finding a job
- ☐ Finding a dentist
- ☐ Finding an eye doctor
- ☐ Family planning
- ☐ Other _____

I have other questions or worries: ☐Yes ☐No

If you want to, you can write them below:

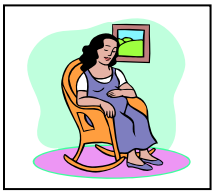
_____

_____

_____

_____

THANK YOU! WE LOOK FORWARD TO WORKING WITH YOU.



MSS PLAN FOR MOTHER'S CARE

☐ ALL BASIC HEALTH MESSAGES WILL BE GIVEN, ACCORDING TO AGENCY'S PROTOCOL
☐ BASIC REFERRALS AND LINKAGES WILL BE MADE

DATE IDENTIFIED & STAFF INITIALS	AREA OF FOCUS	PLAN OF ACTION (DATE IF REVISING)	NOTES/OUTCOMES
	ANTEPARTUM ☐ RISK FACTOR 1: PRENATAL CARE	☐ MINIMUM INTERVENTIONS* ☐ OTHER	
	ANTEPARTUM ☐ RISK FACTOR 2: ADJUSTMENT TO PREGNANCY	☐ MINIMUM INTERVENTIONS* ☐ OTHER	
	ANTEPARTUM ☐ RISK FACTOR 3: MATERNAL GRIEF/LOSS	☐ MINIMUM INTERVENTIONS* ☐ OTHER	
	ANTEPARTUM ☐ OTHER:		
	☐ BASIC NEEDS/SAFETY/ ENVIRONMENT	☐ MINIMUM INTERVENTIONS* ☐ OTHER	
	☐ RISK FACTOR 4: COGNITIVE IMPAIRMENT/ DEVELOPMENTAL DISABILITIES	☐ MINIMUM INTERVENTIONS* ☐ OTHER	
	NUTRITION: ☐ RISK FACTOR 5: FOOD AVAILABILITY	☐ MINIMUM INTERVENTIONS* ☐ OTHER	
	NUTRITION: ☐ RISK FACTOR 6: SKIPPED MEALS	☐ MINIMUM INTERVENTIONS* ☐ OTHER	
	NUTRITION: ☐ OTHER		

DATE IDENTIFIED & STAFF INITIALS	AREA OF FOCUS	PLAN OF ACTION (DATE IF REVISING)	NOTES/OUTCOMES
	☐ RISK FACTOR 7: MEDICAL/HEALTH/ NUTRITION CONDITIONS	☐ MINIMUM INTERVENTIONS* ☐ OTHER	
	POSTPARTUM: ☐ BREASTFEEDING	☐ MINIMUM INTERVENTIONS* ☐ OTHER	
	POSTPARTUM: ☐ ADJUSTMENT TO PARENTING		
	POSTPARTUM: ☐ OTHER		
	☐ RISK FACTOR 8: FAMILY PLANNING	☐ MINIMUM INTERVENTIONS* ☐ OTHER	
	☐ RISK FACTOR 9: TOBACCO USE/ SECONDHAND SMOKE	☐ MINIMUM INTERVENTIONS* ☐ OTHER	
	☐ RISK FACTOR 10: MENTAL HEALTH CONCERNS	☐ MINIMUM INTERVENTIONS* ☐ OTHER	
	☐ RISK FACTOR 11: ALCOHOL/SUBSTANCE USE	☐ MINIMUM INTERVENTIONS* ☐ OTHER	
	☐ RISK FACTOR 12: INADEQUATE SOCIAL SUPPORT	☐ MINIMUM INTERVENTIONS* ☐ OTHER	

Client Name: _____ Date of Birth: _____

Staff Signature(s): _____ Date: _____

Date Identified & Staff Initials	**Area of Focus**	**Plan of Action**	**Notes/Outcomes**
	☐ Risk factor 13: Domestic Violence	☐ Minimum Interventions* ☐ Other	
	☐ Risk Factor 14: CPS Involvement	☐ Minimum Interventions* ☐ Other	
	☐ Risk Factor 15: Coping and Stress	☐ Minimum Interventions* ☐ Other	
	☐ Risk Factor 16: History of abuse	☐ Minimum Interventions* ☐ Other	
	☐ Other		
	☐ Other		

* *As found in MSS Policy and Procedure Manual*

Client Name: _____ Date of Birth: _____

Staff Signature(s): _____ Date: _____

MSS PLAN FOR INFANT'S CARE

☐ ALL BASIC HEALTH MESSAGES WILL BE GIVEN, ACCORDING TO AGENCY'S PROTOCOL
☐ BASIC REFERRALS AND LINKAGES WILL BE MADE

DATE IDENTIFIED & STAFF INITIALS	AREA OF FOCUS	PLAN OF ACTION (DATE IF REVISING)	NOTES/OUTCOMES
	NEWBORN INFANT HEALTH		
	NUTRITION/FEEDING/GROWTH		
	DEVELOPMENT/INFANT BEHAVIOR/ BONDING		
	SAFETY		
	OTHER		

Clinical Charting Forms - Required

HM = Health Message
RF = Risk Factor
* Items = HM or Linkage

MSS PRENATAL NEW CLIENT SCREENING

☐ Home Visit ☐ Office Visit ☐ Other _____ Present at Visit: _____

Date: _____ Time visit started: _____ ☐AM ☐PM Time visit ended: _____☐AM ☐PM

(If 2nd screening visit) Date: _____ Time visit started: _____☐AM ☐PM Time visit ended: _____☐AM ☐PM

Client Name: _____ Date of Birth: _____

Doctor /Midwife's Name: _____ Date Prenatal Care Started: _____

Expected Date to Deliver: _____ Ethnic Group: _____

Receiving medical coupons every month? ☐ Yes ☐ No If so, PIC #: _____

On a Healthy Options Plan? ☐Yes ☐No Which Plan? _____Will the baby have the same plan? ☐Yes ☐No

Are you receiving other prenatal or other case management services? ☐ Yes ☐ No _____

ANTEPARTUM: RF 1 PRENATAL CARE / RF 2 ADJUSTMENT TO PREGNANCY (RF 3 MATERNAL GRIEF)

1. How many times have you been pregnant? _____
2. How many live births have you had? _____
3. How long has it been since you last gave birth? _____
4. **Have you ever had pre-term labor or a premature birth? ☐ Yes ☐ No**
5. Have you ever had a C-section? ☐ Yes ☐ No
6. How many of your children are living with you? _____
7. Was this pregnancy: ☐ planned ☐ not the right time ☐ unexpected ☐ other _____
8. When did you know you were pregnant? _____
9. Which of these areas would you like to learn about? ☐ pregnancy ☐ labor and delivery ☐ newborn care ☐ adjusting to parenting ☐ breastfeeding ☐making your home safe for baby ☐ other _____
10. What are your feelings/baby's father's feelings about this pregnancy?

_____

_____

NOTES:

_____

_____

INTERVENTIONS:

☐ Facilitated appt. with OB provider*
☐ Gave CB Ed schedule*
☐ Gave information re: pediatrician resources*
☐ Informed re: counseling resources*
☐ Referred for counseling*
☐ Gave *Nine Months to Get Ready**
- ☐HM: Importance of prenatal care*
- ☐HM: Physical changes of pregnancy*
- ☐HM: Psychological changes of pregnancy*
- ☐HM: Preterm labor*
- ☐HM: Warning signs in pregnancy*
- ☐HM: Importance of physical exercise in pregnancy*

☐ HM: Bonding and attachment*

COMPLETED BY: _____ _____
STAFF SIGNATURE **DATE**

BASIC NEEDS/SAFETY/ENVIRONMENT

11. What is your living situation?
☐ Buying or ☐ Renting:
☐ apartment ☐ house ☐ room ☐ other _____
Staying: ☐ with friends/family ☐ shelter
☐ car ☐ motel ☐ other_____
12. Who lives with you? _____

_____
13. Do you have smoke detectors in your home?
☐Yes ☐No

NOTES:

_____

_____

INTERVENTIONS:

☐ Referred for housing * _____
☐ Gave housing resources list *
☐ Referred to _____

☐ Referred to _____ (for smoke alarm)*

14. Have you checked them and do they work? ☐Yes ☐No

15. Do you have guns in your home? ☐Yes ☐No

16. Are your guns locked? ☐Yes ☐No

17. Do you have dependable transportation for medical appointments and other activities? ☐Yes ☐ No

18. Do you have a safe car seat for your child? ☐Yes ☐No

19. Are there religious or cultural practices in your life that you would like us to know about to help us serve you better? ☐Yes ☐ No
_____
_____

20. Are you on Temporary Assistance to Needy Families (TANF)? ☐ Applied ☐ Yes ☐ No

21. Are you employed? ☐ Yes ☐ No

22. Is your partner employed? ☐ Yes ☐ No

23. What grade did you last finish in school? _____

☐ Gave gun safety handout
☐ Gave gun lock

☐ Referred for Transportation*
☐ Referred to DSHS *

☐ Gave information re: car seat safety*
☐ Gave car seat resources *
☐ Gave car seat
☐ Gave safety check list
☐ Gave info re: CPR training resources*
☐ Referred to: _____*
☐ Referred to DSHS *
☐ Referred to Employment Security*
☐ HM: Environmental Dangers*

NOTES:
_____
_____

COMPLETED BY: _____ _____
STAFF SIGNATURE **DATE**

RF 4 COGNITIVE IMPAIRMENT/DEVELOPMENTAL DISABILITIES

24. Were there things about school that were especially hard? ☐ Yes ☐ No _____

25. Were you in Special Education classes? ☐ Yes ☐ No

NOTES:
_____
_____

INTERVENTIONS:

☐ Referred for Special Education Services*
☐ Referred for DDD services*

COMPLETED BY: _____ _____
STAFF SIGNATURE **DATE**

NUTRITION: RF 5 FOOD AVAILABILITY / RF 6 SKIPPED MEALS

26. Are you on Food Stamps? ☐ Yes ☐ No ☐ Applied

27. What are your concerns about food, eating, or weight?
_____

28. In the last month, did you ever cut the size of your meals or skip meals because there was not enough money for food or because you were concerned about weight gain? ☐ Yes ☐ No

29. What cravings do you have for non-food items like dirt, cornstarch, paint chips, or ice? _____
_____

30. How much coffee, tea, and soda pop do you drink?
_____

31. How many times per week do you eat out? _____

32. What vitamins or supplements do you take? _____
_____

NOTES:
_____
_____

INTERVENTIONS:

☐ Referred to WIC Agency: _____
☐ Referred to Food Bank*
☐ Discussed ideal eating patterns during pregnancy
☐ Problem-solved ways to avoid skipping meals
☐ Discussed beverage options
☐ HM: Proper nutrition*

COMPLETED BY: _____ _____
STAFF SIGNATURE **DATE**

Client Name: _____ Date of Birth: _____

RF 7 MEDICAL/HEALTH/NUTRITION CONDITIONS

33. Is your blood low in iron? ☐Yes ☐ No ☐ Don't know

34. Do you have high blood pressure? ☐Yes ☐No ☐Don't know

35. Do you now have or did you have diabetes during your pregnancies? ☐ Yes ☐ No ☐ Don't know

36. Do you have any other medical conditions?☐Yes ☐ No

    Condition: _____

37. Are you taking any medicine (prescription, over the counter or other? ☐ Yes ☐ No

38. Have you experienced nausea, vomiting, heartburn, or constipation during your pregnancy? ☐N ☐V ☐H ☐C

39. Have you had problems with weight gain / loss (circle) during this pregnancy? ☐ Yes ☐ No

40. Are your immunizations up to date? ☐Yes ☐ No

41. Have you had a dental check-up in the last year? ☐Yes ☐ No

42. Do you have broken/decayed teeth? ☐Yes ☐ No

43. What regular exercise do you do and how often?

    _____

NOTES:

_____

_____

INTERVENTIONS:

☐ Referred to MD for medical concerns *
☐ Referred to _____ *
☐ HM: Oral Health *

COMPLETED BY: _____ _____
STAFF SIGNATURE **DATE**

POSTPARTUM/BREASTFEEDING PLANS

44. How are you planning to feed your baby?
    ☐ Breast ☐ Bottle ☐ Both

45. Are you planning to go to work or school after birth?
    ☐ Yes ☐ No

NOTES:

_____

_____

INTERVENTIONS:

☐ Referred to BF class *
☐ HM: Breastfeeding (in *Nine Months to Get Ready* *)

COMPLETED BY: _____ _____
STAFF SIGNATURE **DATE**

RF 8 FAMILY PLANNING

46. Are you planning to use birth control after this birth?
    ☐ Interested in learning more
    ☐ Considering birth control
    ☐ Has a plan for birth control
    ☐ Not interested

47. Where will you get your birth control? _____

    _____

NOTES:

_____

_____

INTERVENTIONS:

☐ HM: Family Planning (in *Nine Months to Get Ready*)*
☐ Gave contraception information
☐ Gave information about state-funded contraception and sterilization services

COMPLETED BY: _____ _____
STAFF SIGNATURE **DATE**

Client Name: _____ Date of Birth: _____

RF 9 TOBACCO USE/SECONDHAND SMOKE

48. Have you ever used tobacco? ☐ Yes ☐ No
49. Do you use tobacco now? ☐ Yes ☐ No
50. If yes, would you like help making a plan to quit? ☐ Yes ☐ No
51. Are you exposed to 2nd hand smoke? ☐ Yes ☐ No
52. If yes, would you like help making a plan to stop being exposed? ☐ Yes ☐ No

NOTES:

_____

_____

INTERVENTIONS:

☐ Advised to quit tobacco use (if unwilling, advised to cut down)
☐ No exposure to 2nd hand smoke
☐ Advised to avoid 2nd hand smoke
☐ Helped client develop a quit plan
☐ Helped client develop a plan for remaining tobacco free
☐ Helped client develop a plan for keeping newborn free from exposure to 2nd hand smoke
☐ Gave "No Smoking, Baby Breathing" sign *
☐ Gave 1-800 Quit line card *
☐ Gave Fresh Start information guide *
☐ Gave "How Other Moms Have Quit"
☐ HM: Tobacco/Second Hand Smoke *
☐ Had client sign fax back release form

COMPLETED BY: _____ _____
STAFF SIGNATURE **DATE**

RF 10 MENTAL HEALTH CONCERNS

53. Are you, or is someone else, concerned about your mental health? ☐ Yes ☐ No
54. Have you ever received mental health counseling? ☐ Yes ☐ No
55. Have you ever been depressed? ☐ Yes ☐ No
56. Over the past 2 weeks, have you felt:
    Depressed? ☐ Yes ☐ No Hopeless? ☐ Yes ☐ No
    Unable to enjoy things you usually enjoy? ☐ Yes ☐ No
57. Have you been more irritable/anxious than usual? ☐ Yes ☐ No
58. Are you taking prescription medications? ☐Yes ☐ No

_____

☐ Family hx of depression

☐ In counseling

NOTES:

_____

_____

INTERVENTIONS:

☐ Referred to _____*
☐ Gave handout re: PPMD*
☐ HM: Postpartum Depression*

COMPLETED BY: _____ _____
STAFF SIGNATURE **DATE**

RF 11 ALCOHOL/SUBSTANCE USE

59. Has anyone in your family ever had any problems with drugs or alcohol? ☐ Yes ☐ No
60. Have you used alcohol / drugs *(circle)* just before or during this pregnancy? ☐ Yes ☐ No
61. Have you ever had any problems with drugs or alcohol? ☐ Yes ☐ No
62. Has someone you live with ever had any problems with drugs / alcohol *(circle)*? ☐ Yes ☐ No

NOTES:
☐ In treatment

_____

_____

INTERVENTIONS:

☐ Referred to substance abuse treatment provider *
☐ Referred to AA *
☐ Referred to Alanon *
☐ Referred to NA
☐ HM: Drug/alcohol use during pregnancy *

COMPLETED BY: _____ _____
STAFF SIGNATURE **DATE**

Client Name: _____ Date of Birth: _____

RF 12 SOCIAL SUPPORT

63. Have you / your partner *(circle)* ever had legal problems? ☐ Yes ☐ No
64. Have you / partner *(circle)* ever been in jail? ☐ Yes ☐ No
65. Who can you count on for help / support during this pregnancy?_____
66. Who can you talk to about stressful things in your life? _____

NOTES:

_____

_____

INTERVENTIONS:

☐ Discussed ways to increase support
☐ Referred to legal advocacy resource:_____
☐ HM: Importance of support system*

COMPLETED BY: _____ _____
STAFF SIGNATURE **DATE**

RF 13 DOMESTIC VIOLENCE / RF 14 CPS

67. Do you worry about somebody mistreating you? ☐Yes ☐ No
68. Are you afraid of your partner? ☐ Yes ☐ No
69. Has your partner ever put you down, said hurtful things, or threatened you? ☐ Yes ☐ No
70. Has your partner ever pushed, hit, kicked, or physically hurt you? ☐ Yes ☐ No
71. Has your partner ever threatened or forced you to have sexual contact? ☐ Yes ☐ No
72. Do you worry about anyone mistreating your child / children? ☐Yes ☐ No

☐ Has a safety plan

NOTES:

_____

_____

INTERVENTIONS:

☐ Referred to DV services: _____
☐ Assisted with a safety plan
☐ Facilitated contact with DV services_____
☐ CPS discussed
☐ CPS report made *

COMPLETED BY: _____ _____
STAFF SIGNATURE **DATE**

RF 15 COPING AND STRESS

73. What are some of the ways that you cope with stress? _____
74. How well do these things work for you?

    Not at all OK Very well *(circle)*

75. When problems come up in your life, how do you feel about your ability to handle them? I usually need:

    A lot of help Some help No help *(circle)*

76. What are some of the ways you deal with anger? (yours/other people's) _____
77. How well do these things work for you?

    Not at all OK Very well *(circle)*

NOTES:

_____

_____

INTERVENTIONS:

☐ Discussed potential effects of stress in pregnancy
☐ Discussed strategies for coping with stress
☐ Referred to _____*
☐ HM: Self care and coping *

COMPLETED BY: _____ _____
STAFF SIGNATURE **DATE**

Client Name: _____ Date of Birth: _____

RF 16 HISTORY OF ABUSE AND OTHER ISSUES

78. Is there anything else that is causing you to worry or have concerns about your pregnancy, your family, your living situation, or another part of your life?

☐ History of physical/sexual abuse

NOTES:

_____

_____

INTERVENTIONS:

☐ Referred to _____*

COMPLETED BY: _____ _____

STAFF SIGNATURE **DATE**

☐ Obtained authorizations for exchange of information

NEXT STEPS

Refer to: ☐MSS Nurse ☐MSS Behavioral Health Specialist ☐MSS Nutritionist ☐MSS CHW ☐Other _____

☐ Recommend further evaluation re: _____

☐ **Develop Plan of Care based on issues identified in screening visit(s) and with input from client**

Next Appointment Date: _____

Notes *(Optional)*: _____

_____

_____

_____

_____

Staff Signature: _____ **Date:** _____

Client Name: _____ Date of Birth: _____

MSS POSTPARTUM NEW CLIENT SCREENING

HM = Health Message
RF = Risk Factor
* Items = HM or Linkage

☐ Home Visit ☐ Office Visit ☐ Other _____ Present at Visit: _____

Date: _____ Time visit started _____ ☐AM ☐PM Time visit ended: _____ ☐AM ☐PM
(If 2nd screening visit) Date: _____ Time visit started _____ ☐AM ☐PM Time visit ended: _____ ☐AM ☐PM

Client Name: _____ Date of Birth: _____

Date Prenatal Care Began: _____ Doctor / Midwife's Name: _____

Baby's Name: _____ Baby's Date of Birth: _____

Are you receiving Medical Coupons every month? ☐ Yes ☐ No PIC #: _____

On a Healthy Options Plan? ☐Yes ☐No Which Plan? _____ Is baby's doctor on that plan? ☐Yes ☐No

Are you receiving other postpartum support services? ☐ Yes ☐ No _____

POSTPARTUM: BREASTFEEDING/ADJUSTMENT TO PARENTING

1. How many times have you been pregnant?_____
2. How many live births have you had? _____
3. How long has it been since you last gave birth? _____
4. Was your delivery: ☐ Vaginal ☐ C-section?
5. Did you have any infections? ☐Yes ☐ No
6. Did you have any health conditions during your pregnancy, such as: ☐Hepatitis B ☐HIV ☐TB?
7. Are you having any problems related to your delivery? ☐Yes ☐No
8. When is your next check up with your doctor? _____
9. Are you taking any medicines, (prescription, over-the-counter or other?) ☐Yes ☐No
10. Are you bleeding? ☐Yes ☐No
11. Are you having pain? ☐ Yes ☐No
12. Are you having any other problems, such as fever? ☐Yes ☐No
13. Are you having any problems urinating? ☐Yes ☐No
14. Are you having normal bowel movements? ☐Yes ☐No
15. Are you breastfeeding? ☐ Yes ☐ No ☐ Sometimes
16. Do you have any questions about breastfeeding? ☐Yes ☐No
17. Are you drinking 4 – 6 8 oz glasses of liquid per day? ☐Yes ☐No
18. How is your appetite? ☐ Same as before ☐Poor ☐ Increased
19. Are you concerned about your weight? ☐Yes ☐No
20. How are you sleeping, when you get the chance?
    ☐ No problems sleeping ☐Hard time falling asleep
    ☐ Waking up more than usual ☐Nightmares

☐ Group B Strep
☐ Hepatitis B
☐ HIV
☐ TB

NOTES:

_____
_____
_____
_____
_____
_____

INTERVENTIONS:

☐ Referred to doctor for _____
☐ Facilitated appointment with doctor
☐ Teaching re: postpartum self care
☐ Assisted with breastfeeding
☐ Developed breastfeeding support plan
☐ Referred to _____ for breastfeeding support*
☐ HM: Breastfeeding (in *Nine Months to Get Ready* *)
☐ HM: Self Care for Mom*
☐ HM: Post Partum Mood Disorders*
☐ Other: _____

COMPLETED BY: _____ _____
STAFF SIGNATURE **DATE**

21. Do you get all the help you need with the baby? ☐Yes ☐No

22. What advice are you getting from family and/or friends about taking care of yourself?_____

_____

NOTES:

_____

_____

_____

_____

COMPLETED BY: _____ _____
STAFF SIGNATURE **DATE**

BASIC NEEDS/SAFETY/ENVIRONMENT

23. What is your living situation?
☐ Buying or ☐ Renting:
☐ apartment ☐ house ☐ room ☐ other_____
Staying: ☐ with friends/family ☐ shelter
☐ car ☐ motel ☐ other_____

24. Who lives with you?

_____

_____

25. Do you have smoke detectors in your home? ☐Yes ☐No

26. Have you checked them, and do they work? ☐Yes ☐No

27. Do you have guns in your home? ☐Yes ☐No

28. Are your guns locked? ☐Yes ☐No

29. Do you have dependable transportation for medical appointments and other activities? ☐Yes ☐No

30. Do you have a safe car seat for your child? ☐Yes ☐No

31. Are there religious or cultural practices in your life that you'd like to tell us about to help us serve you better?
☐Yes ☐No _____

32. Are you on Temporary Assistance to Needy Families (TANF)? ☐ Applied ☐Yes ☐No

33. Are you employed? ☐Yes ☐No

34. Are you planning to go to work or school? ☐Yes ☐No

35. Is your partner employed? ☐Yes ☐No

36. What grade did you last finish in school? _____

NOTES:

_____

_____

_____

INTERVENTIONS:

☐ Referred for housing*
☐ Gave housing resources list _____*
☐ Referred to:_____
☐ Referred to _____ (for smoke alarm)

☐ Gave gun safety handout
☐ Gave gun lock
☐ Referred for Transportation*
☐ Referred to DSHS*
☐ Gave information re: car seat safety*
☐ Gave car seat resources*
☐ Gave car seat
☐ Gave safety check list
☐ Gave info re: CPR training resources *
☐ Gave information re: finding childcare
☐ Referred to: _____*
☐ Referred to DSHS*
☐ Referred to Employment Security*
☐ HM: Environmental Dangers*

COMPLETED BY: _____ _____
STAFF SIGNATURE **DATE**

RF 4 COGNITIVE IMPAIRMENT/DEVELOPMENTAL DISABILITIES

37. Were there things about school that were especially hard? ☐Yes ☐ No _____

38. Were you in Special Education classes? ☐Yes ☐No

NOTES:

_____

_____

INTERVENTIONS:

☐ Referred for Special Education Services*
☐ Referred for DDD services *

COMPLETED BY: _____ _____
STAFF SIGNATURE **DATE**

NUTRITION: RF 5 FOOD AVAILABILITY / RF 6 SKIPPED MEALS

39. Are you on Food Stamps? ☐ Applied ☐Yes ☐No
40. What are your concerns about food, eating, or weight?
_____
41. Do you ever cut the size of your meals or skip meals because there isn't enough money for food or because you were concerned about weight gain? ☐Yes ☐No
42. How much coffee, tea, and soda pop do you drink?
_____
43. How many times per week do you eat out?_____
44. What vitamins or supplements do you take? _____
_____

☐ History of eating disorder

NOTES:

_____
_____

INTERVENTIONS:

☐ Referred to WIC Agency: _____
☐ Referred to Food Bank *
☐ Referred for food stamps
☐ Discussed ideal eating patterns during pregnancy
☐ Problem-solved ways to avoid skipping meals
☐ Discussed beverage options
☐ HM: Proper nutrition *

COMPLETED BY: _____ _____
STAFF SIGNATURE **DATE**

RF 7 MEDICAL/HEALTH/NUTRITION CONDITIONS

45. Is your blood low in iron? ☐Yes ☐No ☐ Don't know
46. Do you have high blood pressure? ☐Yes ☐No ☐Don't know
47. Do you now have or did you have diabetes during your pregnancies? ☐ Yes ☐ No ☐ Don't know
48. Do you have any other medical conditions? ☐Yes ☐No
Condition: _____
49. Do you have any concerns about your weight? ☐Yes ☐No
50. Are your immunizations up to date? ☐Yes ☐No
51. ☐ Don't know
52. Have you had a dental check-up in the last year? ☐Yes ☐No
53. Do you have broken/decayed teeth? ☐Yes ☐No
54. What regular exercise do you do and how often?
_____

NOTES:

_____
_____
_____

INTERVENTIONS:

☐ Referred to MD for medical concerns*
☐ Referred to dentist for dental concerns*
☐ Referred to _____ *
☐ HM: Oral Health *

COMPLETED BY: _____ _____
STAFF SIGNATURE **DATE**

RF 8 FAMILY PLANNING

55. Are you planning to use birth control?
☐ Interested in learning more
☐ Considering birth control
☐ Has a plan for birth control
☐ Not interested
56. Where will you get your birth control? _____
_____

NOTES:

_____
_____

INTERVENTIONS:

☐ HM: Family Planning (in *Nine Months to Get Ready*)*
☐ Gave contraception information
☐ Gave information about state funded contraception and sterilization services

COMPLETED BY: _____ _____
STAFF SIGNATURE **DATE**

Client Name:_____ Date of Birth:_____

RF 9 TOBACCO USE/SECONDHAND SMOKE

57. Have you ever used tobacco? ☐Yes ☐No
58. Do you use tobacco now? ☐Yes ☐No
59. Are you thinking about starting to smoke again? ☐Yes ☐No
60. If yes, would you like help making a plan to quit, or keeping from starting again? ☐Yes ☐No
61. Are you exposed to 2nd hand smoke? ☐Yes ☐No
62. If yes, would you like help making a plan to stop being exposed? ☐Yes ☐No

NOTES:

_____

_____

_____

INTERVENTIONS:

☐ Advised to quit tobacco use (if unwilling, advised to cut down)
☐ No exposure to 2nd hand smoke
☐ Advised to avoid 2nd hand smoke
☐ Helped client develop a quit plan
☐ Helped client develop a plan for remaining tobacco free
☐ Helped client develop a plan for keeping newborn free from exposure to 2nd hand smoke
☐ Gave "No Smoking, Baby Breathing" sign *
☐ Gave 1-800 Quit line card *
☐ Gave Fresh Start information guide *
☐ Gave "How Other Moms Have Quit"
☐ HM: Tobacco/Second Hand Smoke *
☐ Had client sign fax back release form

COMPLETED BY: _____ _____
STAFF SIGNATURE **DATE**

RF 10 MENTAL HEALTH CONCERNS

63. Are you or is someone else concerned about your mental health? ☐Yes ☐No
64. Have you ever received mental health counseling? ☐Yes ☐No
65. Have you ever been treated for depression? ☐Yes ☐No
66. Over the past 2 weeks, have you felt:
    Sad, depressed, crying without knowing why? ☐Yes ☐No
    Scared, worried, irritable for no good reason? ☐Yes ☐No
    Unable to enjoy things you usually enjoy? ☐Yes ☐No
    Unable to see the funny side of things as you usually can? ☐Yes ☐No
    Hopeless that things will get better? ☐Yes ☐No
67. Have you had any thoughts of hurting yourself or the baby? ☐Yes ☐No
68. Are you taking medications for mental health reasons? ☐Yes ☐ No _____

☐ Family hx of depression
☐ In counseling:

NOTES:

_____

_____

_____

_____

INTERVENTIONS:

☐ Referred to _____ *
☐ Gave mental health crisis number
☐ Facilitated mental health services appointment
☐ Gave handout re: PPMD*
☐ HM: Postpartum Depression*

COMPLETED BY: _____ _____
STAFF SIGNATURE **DATE**

RF 11 ALCOHOL/SUBSTANCE USE

69. Has anyone in your family ever had any problems with drugs or alcohol? ☐Yes ☐No
70. Have you used alcohol / drugs *(circle*) just before or during your pregnancy? ☐Yes ☐No
71. Has anyone ever told you they were worried about your alcohol / drug use *(circle*)? ☐Yes ☐No
72. Have you ever had any problems with drugs or alcohol? ☐Yes ☐No
73. Has someone you live with ever had any problems with drugs or alcohol (circle)? ☐ Yes ☐No

☐ In treatment

NOTES:

_____

_____

_____

INTERVENTIONS:

☐ Referred to substance abuse treatment provider*
☐ Referred to AA*
☐ Referred to Alanon*
☐ Referred to NA
☐ HM: Drug / alcohol use during pregnancy*

COMPLETED BY:_____ _____
STAFF SIGNATURE **DATE**

RF 12 SOCIAL SUPPORT

74. Have you / your partner *(circle)* ever had legal problems? ☐ Yes ☐ No
75. Have you / partner *(circle)* ever been in jail? ☐Yes ☐No
76. Who can you count on for help / support during this postpartum time?_____
77. Who can you talk with about stressful things in your life? _____

NOTES:

_____

_____

_____

INTERVENTIONS:

☐ Discussed ways to increase support
☐ Referred to legal advocacy resource: _____
☐ HM: Importance of support system *

COMPLETED BY:_____ _____
STAFF SIGNATURE **DATE**

RF 13 DOMESTIC VIOLENCE / RF 14 CPS

78. Do you worry about somebody mistreating you? ☐Yes ☐No
79. Are you afraid of your partner? ☐Yes ☐No
80. Has your partner ever put you down, said hurtful things, or threatened you? ☐Yes ☐No
81. Has your partner ever pushed, hit, kicked, or physically hurt you? ☐Yes ☐No
82. Has your partner ever threatened or forced you to have sexual contact? ☐Yes ☐No
83. Do you worry about anyone mistreating your child / children? ☐Yes ☐No

☐ Has a safety plan

NOTES:

_____

_____

_____

INTERVENTIONS:

☐ Referred to DV services: _____
☐ Assisted with a safety plan
☐ Facilitated contact with DV services_____
☐ CPS discussed
☐ CPS report made *

COMPLETED BY:_____ _____
STAFF SIGNATURE **DATE**

Client Name:_____ Date of Birth:_____

RF 15 COPING AND STRESS

84. What are some of the ways that you cope with stress?
_____

85. How well do these things work for you?

Not at all OK Very well *(circle)*

86. When problems come up in your life, how do you feel about your ability to handle them? I usually need:

A lot of help Some help No help *(circle)*

87. What are some of the ways you deal with anger? (yours / other people's)
_____

88. How well do they work for you?
Not at all OK Very well *(circle)*

NOTES:
_____
_____

INTERVENTIONS:

☐ Discussed potential effects of stress in pregnancy
☐ Discussed strategies for coping with stress

☐ Referred to _____*

☐ HM: Self care and coping *

COMPLETED BY: _____ _____
STAFF SIGNATURE **DATE**

RF 16 HISTORY OF ABUSE AND OTHER ISSUES

89. Is there anything else that is causing you to worry or have concerns in any other areas, such as your family, your living situation or another part of your life? _____
_____
_____
_____

☐ History of physical/sexual abuse

NOTES:
_____
_____
_____

INTERVENTIONS:
☐ Referred to _____*

COMPLETED BY: _____ _____
STAFF SIGNATURE **DATE**

☐ Obtained authorizations for exchange of information

NEXT STEPS

Refer to: ☐MSS Nurse ☐MSS Behavioral Health Specialist ☐MSS Nutritionist ☐MSS CHW ☐Other _____
☐ Recommend further evaluation re: _____

☐ **Develop Plan of Care based on issues identified in screening visit(s) and with input from client**

Next Appointment Date: _____

Notes *(Optional)*:
_____
_____
_____
_____

Staff Signature: _____ **Date:** _____

Client Name:_____ Date of Birth:_____

HM = Health Message
* Items = HM or Linkage

MSS POSTPARTUM RETURNING CLIENT SCREENING

☐ Home Visit ☐ Office Visit ☐ Other _____ Present at visit: _____

Today's Date: _____ Time visit started: _____☐AM ☐PM Time visit ended: _____ ☐AM ☐PM

(If 2nd screening visit) Date: _____Time visit started: _____ ☐AM ☐PM Time visit ended: _____☐AM ☐PM

Client Name: _____ Date of Birth: _____

Baby's Name: _____ Doctor / Midwife's Name: _____

Baby's Date of Birth**:** _____ Still receiving Medical Coupons every month? ☐ Yes ☐ No

PIC #: _____ Which Health Options Plan? _____ ☐None

Is baby's doctor on that plan? ☐ Yes ☐ No Which plan does your baby have? _____

Are you receiving other postpartum support services? ☐ Yes ☐ No _____

POSTPARTUM: BREASTFEEDING/ADJUSTMENT TO PARENTING

1. Was your delivery ☐ Vaginal ☐ C-section?
2. Did you have any infections? ☐ Yes ☐ No
3. Are you having any problems related to your delivery? ☐ Yes ☐ No
4. When is your next check up with your doctor? _____
5. Are you taking any medicines, (prescription, over-the-counter or other?) ☐ Yes ☐ No
6. Are you bleeding? ☐ Yes ☐ No
7. Are you having pain? ☐ Yes ☐ No
8. Are you having any other problems, such as fever? ☐ Yes ☐ No
9. Are you having any problems urinating? ☐ Yes ☐ No
10. Are you having normal bowel movements? ☐ Yes ☐ No
11. Are you breastfeeding? ☐ Yes ☐ No ☐ Sometimes
12. Do you have any questions about breastfeeding? ☐ Yes ☐ No
13. How is your appetite? ☐ Same as before ☐Poor ☐ Increased
14. Are you drinking 4 – 6 8 oz glasses of liquid per day? ☐ Yes ☐ No
15. Are you concerned about your weight? ☐ Yes ☐ No
16. How are you sleeping, when you get the chance?
    ☐ No problems sleeping ☐Hard time falling asleep
    ☐ Waking up more than usual ☐Nightmares
17. Do you get all the help you need with the baby? ☐ Yes ☐ No
18. What advice are you getting from family and/or friends about taking care of yourself? _____

    _____

☐ Group B Strep
☐ Hepatitis B
☐ HIV
☐ TB

NOTES:

_____

_____

_____

_____

_____

INTERVENTIONS:

☐ Referred to doctor for _____
☐ Facilitated appointment with doctor
☐ Teaching re: postpartum self care
☐ Assisted with breastfeeding
☐ Developed breastfeeding support plan
☐ Referred to _____ for breastfeeding support*
☐ HM: Breastfeeding (in *Nine Months to Get Ready**)
☐ HM: Self Care for Mom*
☐ HM: Post Partum Mood Disorders*
☐ Other: _____

COMPLETED BY: _____ _____
STAFF SIGNATURE **DATE**

19. Over the past 2 weeks, have you felt:

Sad, depressed, crying without knowing why? ☐Yes ☐No

Scared, worried, irritable for no good reason? ☐Yes ☐No

Unable to enjoy things you usually enjoy? ☐Yes ☐No

Unable to see the funny side of things as you usually can? ☐Yes ☐No

Hopeless that things will get better? ☐Yes ☐No

20. Have you had any thoughts of hurting your self or the baby? ☐Yes ☐No

21. Is there anything else that is causing you to worry or have concerns in any other areas, such as your family, your living situation, or another part of your life? ☐Yes ☐ No

_____

_____

☐ Family hx of depression
☐ In counseling: _____

NOTES:

_____

_____

_____

_____

INTERVENTIONS:

☐ Referred to _____ *
☐ Gave mental health crisis number
☐ Facilitated mental health services appointment
☐ Gave handout re: PPMD*
☐ HM: Postpartum Depression*

COMPLETED BY: _____ _____
STAFF SIGNATURE **DATE**

RF 9 TOBACCO USE/SECONDHAND SMOKE

22. Do you use tobacco now? ☐Yes ☐No

23. Are you thinking about starting to smoke again? ☐Yes ☐No

24. If yes, would you like help making a plan to quit, or keeping from starting again? ☐Yes ☐No

25. Are you exposed to 2nd hand smoke? ☐Yes ☐No

26. If yes, would you like help making a plan to stop being exposed? ☐Yes ☐No

NOTES:

_____

_____

_____

INTERVENTIONS:

☐ Advised to quit tobacco use (if unwilling, advised to cut down)
☐ No exposure to 2nd hand smoke
☐ Advised to avoid 2nd hand smoke
☐ Helped client develop a quit plan
☐ Helped client develop a plan for remaining tobacco free
☐ Helped client develop a plan for keeping newborn free from exposure to 2nd hand smoke
☐ Gave "No Smoking, Baby Breathing" sign*
☐ Gave 1-800 Quit line card*
☐ Gave Fresh Start information guide*
☐ Gave "How Other Moms Have Quit"
☐ HM: Tobacco/Second Hand Smoke*
☐ Had client sign fax back release form

COMPLETED BY: _____ _____
STAFF SIGNATURE **DATE**

RF 11 ALCOHOL / SUBSTANCE USE ***(COMPLETE THE FOLLOWING IF RISK FACTOR WAS PRESENT DURING PREGNANCY)***

28. Has your alcohol / drug *(circle)* use changed since your baby was born? ☐ Yes ☐ No

_____

_____

29. Has the alcohol / drug *(circle)* use of someone you live with changed since your baby was born? ☐ Yes ☐ No

30. Is there anything else that is causing you to worry or have concerns in any other areas, such as your family your living situation or another part of your lfie? _____

_____

_____

NOTES:

_____

_____

_____

☐ In treatment: _____

_____

_____

INTERVENTIONS:

☐ Referred to Growing Together *
☐ Referred to AA *
☐ Referred to Alanon *
☐ Referred to NA
☐ HM: Drug / alcohol use during pregnancy *

COMPLETED BY:_____ _____
STAFF SIGNATURE **DATE**

NEXT STEPS

Refer to: ☐MSS Nurse ☐MSS Behavioral Health Specialist ☐MSS Nutritionist ☐MSS CHW ☐Other _____

☐ Recommend further evaluation re: _____

☐ **Develop Plan of Care based on issues identified in screening visit(s) and with input from client**

Next Appointment Date: _____

Notes (Optional): _____

_____

_____

_____

_____

Staff Signature: _____ **Date:** _____

Client Name: _____ Date of Birth: _____

MSS INITIAL INFANT SCREENING

HM = Health Message
* = HM or Linkage

☐ Home Visit ☐ Office Visit ☐ Other _____ Present at Visit: _____

Today's Date: _____ Time visit started: _____☐AM ☐PM Time visit ended: _____ ☐AM ☐PM

(If 2nd screening visit) Date: _____Time visit started: _____ ☐AM ☐PM Time visit ended: _____ ☐AM ☐PM

Baby's Name: _____ ☐M ☐F Date of Birth: _____ Gestation: _____wks

Doctor's Name: _____ Which Healthy Options Plan is your baby on? _____

Mother's Name: _____ Date of Birth: _____

NEWBORN INFANT HEALTH

1. How much did your baby weigh at birth? →
2. How long was he/she? →
3. How much does your baby weigh now? →
4. What was your baby's head circumference? →
5. Did you or your baby have any health problems at the time of birth, or in the hospital? _____
6. If so, did the doctor tell you to bring the baby in for follow-up? _____
7. Did your baby have her/his newborn screening heel stick? ☐Yes ☐No
8. Did your baby have her/his first newborn checkup at the doctor's office? ☐ Yes ☐No
9. If not, when is the appointment? _____
10. Do you know at what ages your baby needs his/her shots? (immunizations) ☐ Yes ☐ No
11. How many wet diapers does your baby have in 24 hrs? →
12. How many dirty diapers (bowel movements) does your baby have in 24 hours? →
13. Does anyone ever smoke around your baby? ☐ Yes ☐No
    ☐ In same room ☐ In house ☐ In car
14. Do you have any concerns about your baby's health? _____ ☐Yes ☐No
15. Do you know some signs to look for that might mean your baby is sick? _____ ☐ Yes ☐No
16. Do you know how to take your baby's temperature? ☐ Yes ☐No
17. Do you have a thermometer? ☐ Yes ☐No
18. When did your baby's doctor say you should call him/her about:
    Jaundice (yellow skin) _____
    Fever _____
    Other signs of illness _____
19. Do you know how to reach your baby's doctor after hours? ☐ Yes ☐No
20. Do you know what kinds of things you can do to protect your baby's future teeth? ☐ Yes ☐No

Birth weight _____ Current weight _____

Birth length _____ Head circumference _____

☐ Group B Strep ☐ TB ☐ HIV ☐ Hepatitis B
☐ Other _____
☐ Had follow-up: _____
☐ Needs follow-up: _____
☐ Mother can take temperature and interpret reading
☐ Knows not to put baby to bed with a bottle

NOTES:

_____

_____

_____

_____

_____

# of wet diapers / 24 hrs _____

# of bowel movements / 24 hrs _____

INTERVENTIONS:

☐ Discussed how to ask others not to smoke near baby
☐ Gave info re: dangers of second hand smoke
☐ Gave info re: smoking and breast milk
☐ Gave MYFSF Booklet
☐ Gave Quit line
☐ Checked cord
☐ Reviewed cord care instructions
☐ Gave health promotion information
☐ Reviewed immunization schedule
☐ Reviewed instructions for taking temperature
☐ Reviewed how to reach provider after hours
☐ Gave basic oral health information
☐ Other: _____
☐ HM: Baby Basics*
☐ HM: Well child visits
☐ Facilitated appointment with baby's doctor

Referred to:
☐ MD
☐ Other _____

COMPLETED BY: _____ _____
STAFF SIGNATURE **DATE**

NUTRITION/FEEDING/GROWTH

21. Are you breastfeeding your baby?
☐ Yes ☐ No ☐ Sometimes

22. Are you formula feeding your baby?
☐ Yes ☐ No ☐ Sometimes

23. How often do you feed your baby? _____

24. Are you feeding your baby anything other than breast milk or formula? ☐ Yes ☐ No _____

25. Do you have any questions about feeding? ☐ Yes ☐No
_____

26. Do you have any questions or concerns about your baby's growth? ☐ Yes ☐No

_____

_____

_____

_____

NOTES:

_____

_____

_____

INTERVENTIONS:

☐ HM: Breastfeeding (In *Nine Months to Get Ready* *)
☐ Assistance with breastfeeding
☐ Gave information re: nutritional needs
Referred to:
☐ WIC
☐ Dietician
☐ Lactation Consultant
☐ _____ for breastfeeding support
☐ MD
☐ Other _____

COMPLETED BY: _____ _____
STAFF SIGNATURE **DATE**

DEVELOPMENT/INFANT BEHAVIOR/BONDING

27. What are your baby's sleep patterns? _____

_____

28. Are there times when your baby is usually alert?
☐ Yes ☐ No

29. Are there times when s/he's usually fussy?
☐ Yes ☐ No

30. Is your baby usually easy to calm down when s/he's fussy?
☐ Yes ☐ No

31. When your baby is crying, can you usually tell what s/he seems to need? ☐ Yes ☐ No

32. How would you describe your baby's personality (temperament)? _____

33. (If baby's father is involved) Has your baby's father described your baby's personality (temperament)?

_____

34. What advice about taking care of your baby do you get from your family and /or friends? _____

_____

_____

_____

☐ Sleep patterns appear typical for age
☐ Fussy periods appear typical for age
☐ Awake periods appear typical for age
☐ Mother describes baby in positive terms
☐ Mother's behavior indicates sensitivity
☐ Mother is appropriately responsiveness to baby

NOTES:

_____

_____

_____

INTERVENTIONS:

☐ Discussed that one can't "spoil" an infant
☐ Gave age appropriate developmental information
☐ HM: Bonding and Attachment*
☐ Referred for developmental evaluation
☐ Referred to Parenting Class
☐ Referred to MD
☐ Other: _____

COMPLETED BY: _____ _____
STAFF SIGNATURE **DATE**

Client Name: _____ Date of Birth: _____

SAFETY

35. Does your baby sleep on his/her back? ☐Yes ☐No
36. Do you know infant CPR? ☐ Yes ☐ No
37. Does your baby ride in an infant seat every time? ☐ Yes ☐ No
38. Do you know about the dangers of shaking a baby or tossing them in the air? ☐ Yes ☐ No
39. Do you have pets? ☐ Yes ☐ No
40. Are there any unwanted animal pests in or around your home? ☐ Yes ☐ No
41. Are you concerned about someone hurting your baby? ☐ Yes ☐ No

NOTES:

_____

_____

☐ Mother knows never to shake infant

Pets inside: _____

Pets outside: _____

Animal Pests: _____

INTERVENTIONS:

☐ Contacted _____ to advocate for client
(agency)

☐ Gave information re: animal safety
☐ Gave information re: dangers of shaking baby
☐ Referred for CPR training
☐ Gave car seat safety information
☐ Gave car seat
☐ Gave Back to Sleep / SIDS information
☐ HM: Baby Basics*
☐ Other: _____

COMPLETED BY: _____ _____
STAFF SIGNATURE **DATE**

OTHER

42. Do you need to look for childcare? ☐ Yes ☐ No
43. Are there certain areas you would like to learn more about? For example:
    - ☐ infant / baby care
    - ☐ dealing with infant crying
    - ☐ when to call my baby's doctor
    - ☐ how my baby lets me know what s/he needs
    - ☐ infant feeding
    - ☐ ways to play with my baby
    - ☐ how to make my home safer
    - ☐ other: _____
44. Is there anything else that is causing you to worry or have concerns in any other areas, such as your family, your living situation, or another part of your life? ☐ Yes ☐ No

NOTES:

_____

_____

_____

_____

_____

INTERVENTIONS:

☐ Gave information re: finding childcare
☐ Other: _____

COMPLETED BY: _____ _____
STAFF SIGNATURE **DATE**

☐ Obtained authorizations for exchange of information

NEXT STEPS

Refer to: ☐MSS Nurse ☐MSS Behavioral Health Specialist ☐MSS Nutritionist ☐MSS CHW ☐Other _____

☐ Recommend further evaluation re: _____
☐ **Develop Plan for Care based on issues identified in screening visit(s) and with input from client**

Notes *(Optional)*: _____

_____

Staff Signature: _____ **Date:** _____

Next Appointment Date: _____

Client Name: _____ Date of Birth: _____

MSS CLIENT VISIT RECORD WITH MOTHER

Client Name: _____ Date of Birth: _____ Visit Date: _____

☐ HV ☐ OV Present at visit: _____

Time visit started: _____ ☐ AM ☐ PM Time visit ended: _____ ☐ AM ☐ PM

☐ See Infant's Chart for Additional Information: _____
Infant's Name

**Asterisked items indicate linkages and health messages (HM). Descriptions of minimum interventions can be found in the First Steps Policy and Procedures Manual under Client Services. RF = Risk Factor*

FOLLOW-UP FROM LAST VISIT	Has Plan	Contacted	Received	**INTERVENTION/ACTIONS**	**NOTES**
ANTEPARTUM: RF 1 PRENATAL CARE / RF 2 ADJUSTMENT TO PREGNANCY (RF 3MATERNAL GRIEF)					
OB provider:	☐	☐	☐	☐ Gave list of OB providers*	
Childbirth Ed:	☐	☐	☐	☐ Facilitated appt. with OB provider*	
Breastfeeding Class:	☐	☐	☐	☐ Gave Childbirth Ed schedule*	
Other:				☐ Facilitated registration for CBE class ☐ Referred to breastfeeding class* ☐ Gave *Healthy Mothers/Healthy babies phone #* ☐ Gave *Nine Months to Get Ready** ☐ HM: Importance of prenatal care* ☐ HM: Physical changes of pregnancy* ☐ HM: Psychological changes of pregnancy* ☐ HM: Preterm labor* ☐ HM: Warning signs of pregnancy ☐ HM: Importance of physical exercise in pregnancy* ☐ HM: Bonding and attachment* ☐ Other _____	
BASIC NEEDS/SAFETY/ENVIRONMENT					
DSHS:	☐	☐	☐	☐ Referred to DSHS*	
Housing:	☐	☐	☐	☐ Gave housing resources list	
Transportation:	☐	☐	☐	☐ Referred for housing application*	
Clothing:	☐	☐	☐	☐ Referred for transportation*	
Work:	☐	☐	☐	☐ Referred to Employment Security*	
School:	☐	☐	☐	☐ Referred for school: _____*	
Smoke Alarm:	☐	☐	☐	☐ Referred to _____ (smoke alarm)*	
Other:				☐ Gave information re: car seat safety* ☐ Gave car seat resources* ☐ Gave car seat ☐ Gave safety check list ☐ Gave gun safety handout ☐ Gave gun lock ☐ Gave info re: CPR training resources* ☐ Referred to: _____* ☐ HM: Environmental Dangers* ☐ Other_____	

FOLLOW-UP FROM LAST VISIT	Has Plan	Contacted	Received	**INTERVENTIONS/ACTIONS**	**NOTES**
RF 4 COGNITIVE IMPAIRMENT/DEVELOPMENTAL DISABILITIES					
DDD: ☐☐☐ Special Ed: ☐☐☐ Other:				☐ Referred for Special Education Services* ☐ Referred for DDD services* ☐ Assisted in obtaining DDD services* ☐ Other_____	
NUTRITION: RF 5 FOOD AVAILABILITY / RF 6 SKIPPED MEALS					
Food Bank: ☐☐☐ Food Stamps: ☐☐☐ Other:				☐ Referred to Food Bank* ☐ Referred for Food Stamps* ☐ Discussed ideal eating patterns ☐ Addressed avoiding skipping meals ☐ Discussed question of eating disorder ☐ Discussed beverage options ☐ Discussed iron rich foods ☐ Other _____	
RF 7 MEDICAL/HEALTH/NUTRITION CONDITIONS					
MD: ☐☐☐ Oral health: ☐☐☐ Other:				☐Specific Condition(s)_____ _____ ☐Referred to MD for medical concerns* ☐Referred to oral health resources* ☐Facilitated oral health/medical appointment * ☐ HM: Oral Health* ☐ Other _____	
POSTPARTUM/BREASTFEEDING/PARENTING					
Breastfeeding Support: ☐☐☐ Parenting Class: ☐☐☐ ☐☐☐ Mom's MD: ☐☐☐ Other:				☐ Discussed benefits of breastfeeding ☐ Assisted with breastfeeding ☐ Referred to _____for breastfeeding support* ☐ Referred to Parenting Class* ☐ Referred to MD* ☐ HM: Well Child Care* ☐ HM: Baby Basics* ☐ HM: Bonding and Attachment* ☐ HM: Normal Growth and Development* ☐ HM: Child Profile and Health Promotion* ☐ HM: Self Care for Mom* ☐ HM: Post Partum Mood Disorders* (All in *Nine Months to Get Ready*) ☐ Other: _____	

Client Name: _____ Date of Birth: _____

Staff Initials: _____ Date: _____

FOLLOW- FROM LAST VISIT UP (Has Plan / Contacted / Received)	INTERVENTIONS/ACTIONS	NOTES
RF 8 FAMILY PLANNING		
Family planning method ☐ ☐ ☐ **WILL GET CONTRACEPTION FROM:** ☐Medical Care Provider ☐FP Clinic ☐CSO FP Nurse ☐Other_____ Method Planned_____ Other:	☐ Referred to MD/Nurse Practitioner ☐ Gave contraception information ☐ Gave info about state-funded contraception and sterilization services (Take Charge) ☐ Discussed ideal family size ☐ HM: Family Planning (in *Nine Months to Get Ready*)* ☐ Other _____	☐Stated hopes/dreams re: ideal family size ☐Stated she's thought about HIV and STDs ☐Decided to use contraception
RF 9 TOBACCO USE/SECONDHAND SMOKE		
Quit line: ☐ ☐ ☐ Other:	☐ Advised to quit tobacco use (if unwilling, advised to cut down) ☐ Advised to avoid 2nd hand smoke ☐ Helped client develop a quit plan ☐ Helped client develop a plan for remaining tobacco free ☐ Helped client develop a plan for keeping newborn free from exposure to 2nd hand smoke ☐ Gave "No Smoking, Baby Breathing" sign* ☐ Gave 1-800 Quit line card* ☐ Gave Fresh Start information guide* ☐ Gave "How Other Moms Have Quit" ☐ Referred to available support systems _____ _____ ☐ HM: Tobacco/Second Hand Smoke ☐ Had client sign fax back release form	☐No current tobacco use ☐No change in tobacco use ☐Change in tobacco use _____ ☐No interest in changing tobacco use ☐Interest in changing tobacco use ☐No change in 2nd hand exposure ☐Change in 2nd hand exposure _____ ☐No interest in changing 2nd handexposure ☐ Interest in decreasing 2nd hand exposure ☐Decreased 2nd hand exposure
RF 10 MENTAL HEALTH CONCERNS		
Counseling: ☐ ☐ ☐ Other:	☐ Informed of counseling options* ☐ Assisted in obtaining mental health services* ☐ Other _____	
RF 11 ALCOHOL/SUBSTANCE USE		
AA: ☐ ☐ ☐ Al Anon: ☐ ☐ ☐ NA: ☐ ☐ ☐ Treatment: ☐ ☐ ☐ Other:	☐ Discussed risks of alcohol and other substance use to the baby ☐ Assisted in obtaining treatment services* ☐ Referred to _____ * ☐ Referred to AA ☐ Referred to Al Anon* ☐ Referred to NA* ☐ Other _____	☐No interest in changing alcohol use ☐Interest in changing alcohol use ☐Decreased alcohol use to _____ ☐Stopped alcohol use ☐No change ☐No interest in changing drug use ☐Interest in changing drug use ☐Decreased drug use ☐Stopped drug use ☐In treatment ☐No change

Client Name: _____ Date of Birth: _____

Staff Initials: _____ Date: _____

FOLLOW-UP FROM LAST VISIT Has Plan Contacted Received	**INTERVENTIONS/ACTIONS**	**NOTES**
RF 12 SOCIAL SUPPORT		
Social support: ☐ Has Plan ☐ Improved	☐ Discussed ways to increase support system ☐ Discussed ways to increase support ☐ Referred to legal advocacy resource: _____ ☐ HM: Importance of support system* ☐ Other _____	
RF 13 DOMESTIC VIOLENCE / RF 14 CPS		
DV Services: ☐ ☐ ☐ CPS Services: ☐ ☐ ☐ Other:	☐ Referred to DV services: _____ ☐ Offered assistance in obtaining DV services* ☐ Assisted with a safety plan ☐ CPS discussed ☐ CPS report made* ☐ Assisted in engaging with CPS Services* ☐ Other: _____	
RF 15 COPING AND STRESS		
Coping strategies: ☐ Has Plan ☐ Improved Other:	☐ Discussed potential effects of stress in pregnancy ☐ Discussed strategies for coping with stress ☐ HM: Self care and coping* ☐ Other _____	
RF 16 HISTORY OF ABUSE AND OTHER ISSUES		
Other:	☐ Abuse issues explored ☐ Other: _____	

Referred to MSS: ☐ Behavioral Health Specialist ☐ Nutritionist ☐ Nurse ☐ Community Health Worker ☐ Other: _____

Next Steps: _____

Staff Signature: _____ Next Appointment: _____

Client Name: _____ Date of Birth: _____

Staff Initials: _____ Date: _____

MSS CLIENT VISIT RECORD WITH INFANT

Client Name:_____ Date of Birth: _____ Visit Date: _____

Time visit started: _____ ☐ AM ☐ PM Time visit ended: _____ ☐ AM ☐ PM

☐ HV ☐ OV Present at visit: _____

☐ See Mother's Chart for additional information: _____
Mother's Name

**Asterisked items indicate linkages and health messages (HM). Descriptions of minimum interventions can be found in the First Steps Policy and Procedures Manual under Client Services. RF = Risk Factor*

FOLLOW-UP FROM LAST VISIT	Has Plan	Contacted	Received	**INTERVENTION/ACTIONS**	**NOTES**
NEWBORN INFANT HEALTH					
Well Child Care: Immunizations: MD: Other:	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐Helped client develop a plan for keeping newborn free from exposure to 2nd handsmoke ☐Well child health promotion ☐Referred to MD for well child visit ☐Referred to MD for medical concerns re: infant Specific Condition(s) _____ _____ ☐Contacted _____ to advocate for client *(agency)* ☐Other _____ ☐Referred to oral health resources ☐Facilitated oral health/medical appointment ☐ HM: Well Child Care* ☐ HM: Baby Basics* ☐ HM: Child Profile and Health Promotion ☐ HM: Tobacco/Second Hand Smoke*	☐No change in 2nd hand exposure ☐Change in 2nd hand exposure _____ _____ ☐No interest in changing 2nd hand exposure ☐Interest in decreasing 2nd hand exposure ☐Decreased 2nd hand exposure ☐Stopped 2nd hand exposure
NUTRITION/FEEDING/GROWTH					
Breastfeeding support: WIC Dietician Lactation Consultant MD Other:	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	Referred to: ☐WIC ☐ Dietician ☐Lactation Consultant ☐_____ for breastfeeding support ☐ MD ☐Other _____ ☐Assistance with breastfeeding ☐ Gave information re: nutritional needs ☐ Nutrition/feeding information ☐ HM: Breastfeeding (in *Nine Months to Get Ready**)	☐Growth appears within standard guidelines

Staff Initials: _____ Date: _____

FOLLOW-UP FROM LAST VISIT	Has Plan	Contacted	Received	**INTERVENTIONS/ACTIONS**	**NOTES**
DEVELOPMENT/INFANT BEHAVIOR/BONDING					
MD	☐	☐	☐	☐ Discussed that one can't "spoil" an infant ☐ Gave age appropriate developmental information ☐ Referred for developmental evaluation	☐Sleep patterns appear typical for age ☐Awake periods appear typical for age ☐Fussy periods appear typical for age ☐Mother demonstrates bonding with infant ☐Mother describes baby in positive terms ☐Mother demonstrates sensitivity and appropriate responsiveness to baby
SAFETY					
Smoke Alarm Car Seat Other:	☐ ☐	☐ ☐	☐ ☐	☐ Referred to _____ (smoke alarm)* ☐ Gave information re: car seat safety* ☐ Gave car seat resources* ☐ Gave car seat ☐ Gave safety check list ☐ Gave gun safety handout ☐ Gave gun lock ☐ Gave info re: CPR training resources* ☐ Referred to: _____* ☐ HM: Back to Sleep ☐ HM: SIDS ☐ HM: Environmental Dangers* ☐ Other_____ ☐ Given car seat ☐ Contacted _____ to advocate for client. *(agency)* ☐Other _____	Pets inside:_____ Pets outside: _____ Animal Pests: _____ ☐Mother knows never to shake infant
OTHER					
Childcare:	☐	☐	☐	☐ Gave information re: finding childcare ☐ Other: _____	
ICM ENROLLMENT					
☐Infant was enrolled in ICM services ☐Infant was not enrolled in ICM services due to: ☐ Ineligibility ☐ Client declined services ☐ Lost contact with client ☐Mother wanted ICM services, but was not eligible					

Referred to MSS**:** ☐Behavioral Health Specialist ☐Nutritionist ☐Nurse ☐Community Health Worker ☐Other: _____

Next Steps: _____

Staff Signature: _____ Next Appointment: _____

Client Name: _____ DOB: _____

MSS MOTHER'S SERVICE OUTCOME AND DISCHARGE SUMMARY

Client Name: _____

Date Discharged from MSS: _____

REASON FOR DISCHARGE FROM MSS:

☐ Client discontinued services ☐ No longer eligible
☐ Transferred to different agency ☐ Lost to follow-up
☐ Services completed ☐ Client moved
☐ Other _____

RISK FACTOR / INTERVENTION INFORMATION *(Check either the Risk Factor box or the "Not Evident" box and all other boxes that apply.)*	**CLIENT OUTCOME INFORMATION** *(Check highest level[s] outcome achieved)*
☐ **ANTEPARTUM: RISK FACTOR 1: PRENATAL CARE** ☐ Not evident as a risk factor ☐ Assisted in obtaining prenatal care	☐ Began prenatal care at _____ weeks gestation ☐ Obtained postpartum follow-up care on _____ ☐ Unknown
☐ **ANTEPARTUM: RISK FACTOR 2: ADJUSTMENT TO PREGNANCY** ☐ Not evident as a risk factor ☐ Not addressed due to: ☐ Client had other priorities ☐ Client declined to address ☐ Assisted in obtaining services related to exploration of pregnancy options	☐ Considered options, developed adequate plans and resources for parenting ☐ Considered options, working on adequate plan and resources for parenting ☐ Considered options, chose not to address ☐ Client was inconsistently interested in addressing ☐ No change ☐ Unknown
☐ **ANTEPARTUM: RISK FACTOR 3: MATERNAL GRIEF / LOSS** ☐ Not evident as a risk factor ☐ Not addressed due to: ☐ Client had other priorities ☐ Client declined to address ☐ Assisted in obtaining appropriate services	☐ Client reports that grief no longer interferes with her ability to function ☐ Client reports that grief interferes less with her ability to function ☐ Consistently working toward improving ability to function despite grief ☐ Client was inconsistently interested in addressing ☐ No change ☐ Unknown
☐ **BASIC NEEDS / SAFETY / ENVIRONMENT** ☐ Not evident as a risk factor ☐ Not addressed due to: ☐ Client had other priorities ☐ Client declined to address ☐ Assisted in obtaining appropriate services	☐ Client consistently followed up on referrals, and: ☐ Environment is safer ☐ Housing situation has improved ☐ Income situation has improved ☐ No change in situation ☐ _____ ☐ Client inconsistently followed up on referrals, and: ☐ Environment is safer ☐ Housing situation has improved ☐ Income situation has improved ☐ No change in situation ☐ _____ ☐ Client was inconsistently interested in addressing ☐ No change ☐ Unknown

RISK FACTOR / INTERVENTION INFORMATION *(Check either the Risk Factor box or the "Not Evident" box and all other boxes that apply.)*	**CLIENT OUTCOME INFORMATION** *(Check highest level[s] outcome achieved)*
☐ **RISK FACTOR 4: DEVELOPMENTAL DISABILITIES / COGNITIVE IMPAIRMENT** ☐ Not evident as a risk factor ☐ Not addressed due to: ☐ Client had other priorities ☐ Client declined to address ☐ Informed of DDD services ☐ Assisted in obtaining DDD services ☐ Assisted in obtaining Special Education Services	☐ Client unable to obtain DDD services due to ineligibility ☐ Consistently followed up on referrals/resources, and: is receiving DDD services ☐ Client declined DDD services ☐ Client reported interest in DDD services but did not follow-up with referrals ☐ Consistently receiving Special Education services ☐ Client was inconsistently interested in addressing ☐ No change ☐ Unknown
☐ **NUTRITION: RISK FACTOR 5: FOOD AVAILABILITY** ☐ Not evident as a risk factor ☐ Not addressed due to: ☐ Client had other priorities ☐ Client declined to address ☐ Given information re: resources to obtain food	☐ Weight gain within recommended guidelines ☐ Weight gain exceeded guidelines or inadequate ☐ Weight gain less than recommended guidelines ☐ Consistently followed up on referrals/resources ☐ Received food via stamps / food bank / other, and increased food supply ☐ Inconsistently followed up on referrals/resources ☐ Client reported interest in accessing food resources but did not follow-up on referrals ☐ Client was inconsistently interested in addressing ☐ No change ☐ Unknown
☐ **NUTRITION: RISK FACTOR 6: SKIPPED MEALS** ☐ Not evident as a risk factor ☐ Not addressed due to: ☐ Client had other priorities ☐ Client declined to address	☐ Consistently followed up on recommendations and improved nutritional behaviors ☐ Has plan to improve nutritional behaviors ☐ Reported interest in improving nutritional behaviors, but no change in behaviors ☐ Client was inconsistently interested in addressing ☐ No change ☐ Unknown
☐ **RISK FACTOR 7: MEDICAL / HEALTH / NUTRITION CONDITIOS** **SPECIFIC CONDITIONS:** _____ _____ ☐ Not evident as a risk factor ☐ Not addressed due to: ☐ Client had other priorities ☐ Client declined to address ☐ Was assisted in obtaining medical care	☐ Consistently followed up on referrals/appointments, and is consistently receiving medical care ☐ Inconsistently followed up on referrals/appointments and is inconsistently receiving medical care ☐ Reported interest in receiving medical care, but no change in behaviors ☐ Client declined medical care ☐ Client was inconsistently interested in addressing ☐ No change ☐ Unknown

Client Name: _____ Date of Birth: _____

RISK FACTOR / INTERVENTION INFORMATION *(Check either the Risk Factor box or the "Not Evident" box and all other boxes that apply.)*	**CLIENT OUTCOME INFORMATION** *(Check highest level[s] outcome achieved)*
☐ **POSTPARTUM: BREASTFEEDING / ADJUSTMENT TO PARENTING** ☐ Not evident as a risk factor ☐ Not addressed due to: ☐ Client had other priorities ☐ Client declined to address	**BREASTFEEDING** ☐ Consistently followed up on referrals/recommendations and breastfeeding situation is improved ☐ Inconsistently followed up on referrals/ recommendations and breastfeeding situation is not improved ☐ Reported interest in improving situation, but no change in behaviors ☐ Client was inconsistently interested in addressing ☐ No change ☐ Unknown **ADJUSTMENT TO PARENTING** ☐ Consistently followed up on referrals/recommendations and parenting situation is improved ☐ Inconsistently followed up on referrals/ recommendations and parenting situation is not improved ☐ Reported interest in improving situation, but no change in behaviors ☐ Client was inconsistently interested in addressing ☐ No change ☐ Unknown
☐ **RISK FACTOR 8: FAMILY PLANNING** ☐ Client referred for family planning service ☐ Pregnancy planning discussed with client ☐ Discussed HIV and STD prevention ☐ Referred for family planning services STAFF SIGNATURE: _____ DATE: _____	*(Check all that apply)* ☐ Client verbalized her hopes and dreams for her ideal family size ☐ Client reports that she thought about HIV and STDs ☐ Client decided to use contraception ☐ Client planned to obtain contraception from □ Medical Care Provider □ CSO FP Nurse □ FP Clinic □ Other ☐ Client initiated contraception after delivery *(method checked below)* □ Implant □ Cervical Cap □ Injectable □ Spermicides □ IUD □ Abstinence □ Female Sterilization □ MaleSterilization □ Oral Contraceptives □ Breastfeeding □ Emergency Contraception □ Withdrawal □ Condom (male) □ Natural Family Planning □ Condom (female) □ Other _____ □ Diaphragm ☐ Client has appointment to obtain contraception on: _____ ☐ No plan to use contraception ☐ Follow-up needed ☐ Plan: _____ _____ ☐ Unknown STAFF SIGNATURE: _____ DATE: _____

Client Name: _____ Date of Birth: _____

RISK FACTOR / INTERVENTION INFORMATION *(Check either the Risk Factor box or the "Not Evident" box and all other boxes that apply.)*	**CLIENT OUTCOME INFORMATION** *(Check highest level[s] outcome achieved)*
☐ **RISK FACTOR 9: TOBACCO USE / SECONDHAND SMOKE** ☐ Client was advised to quit tobacco use (if unwilling, was advised to cut down) _____ Staff initials and date ☐ Client was advised to avoid 2nd hand smoke and to keep her newborn from being exposed to 2nd hand smoke _____ Staff initials and date ☐ Helped client develop a quit plan ☐ Helped client develop a plan for remaining tobacco free ☐ Helped client develop a plan for keeping newborn free from exposure to 2nd hand smoke ☐ Gave "No Smoking, Baby Breathing" sign * ☐ Gave 1-800 Quit line card * ☐ Gave Fresh Start information guide * ☐ Gave "How Other Moms Have Quit" ☐ Referred to available support systems _____ _____ ☐ HM: Tobacco/Second Hand Smoke * ☐ Had client sign fax back release form	☐ No current tobacco use _____ Staff initials and date ☐ No current interest in changing tobacco use _____ Staff initials and date ☐ Has current interest in decreasing/quitting tobacco use _____ Staff initials and date ☐ Decreased tobacco use to _____ Staff initials and date ☐ Stopped tobacco use _____ Staff initials and date ☐ No change in tobacco use _____ Staff initials and date ☐ No exposure to 2nd hand smoke _____ Staff initials and date ☐ No interest in decreasing 2nd hand exposure _____ Staff initials and date ☐ Interest in decreasing 2nd hand exposure _____ Staff initials and date ☐ Decreased 2nd hand exposure _____ Staff initials and date
☐ **RISK FACTOR 10: MENTAL HEALTH CONCERNS** ☐ Not evident as a risk factor ☐ Not addressed due to: ☐ Client had other priorities ☐ Client declined to address ☐ Was informed about and referred for mental health services ☐ Was assisted in obtaining mental health services	☐ Client unable to obtain mental health services due to lack of service availability or ineligibility ☐ Consistently followed up on referrals/appointments, is consistently receiving mental health care ☐ Inconsistently followed up on referrals/appointments, is inconsistently receiving mental health care ☐ Reported interest in receiving mental health care, but no change in behaviors ☐ Client declined mental health services ☐ Client was inconsistently interested in addressing ☐ No change ☐ Unknown
☐ **RISK FACTOR 11: ALCOHOL / SUBSTANCE USE** ☐ Not evident as a risk factor ☐ Not addressed due to: ☐ Client had other priorities ☐ Client declined to address ☐ Assisted in obtaining treatment services	☐ Client unable to obtain treatment services due to lack of service availability ☐ Consistently followed up on referrals/resources, and: ☐ Client reports stopping substance /alcohol use ☐ Is consistently receiving treatment services ☐ Completed treatment program ☐ Inconsistently followed up on referrals/appointments, ☐ Client reported considering treatment program ☐ Reported interest in receiving treatment services care, but no change in behaviors ☐ Client declined treatment services ☐ Client was inconsistently interested in addressing ☐ No change ☐ Unknown ☐ In treatment program ☐ Client uninterested in treatment ☐ Client was inconsistently interested in addressing ☐ No change ☐ Unknown

Client Name: _____ Date of Birth: _____

RISK FACTOR / INTERVENTION INFORMATION *(Check either the Risk Factor box or the "Not Evident" box and all other boxes that apply.)*	**CLIENT OUTCOME INFORMATION** *(Check highest level[s] outcome achieved)*
☐ **RISK FACTOR 12: INADEQUATE SOCIAL SUPPORT** ☐ Not evident as a risk factor ☐ Not addressed due to: ☐ Client had other priorities ☐ Client declined to address ☐ Informed of importance of social support ☐ Assisted in acquiring adequate social support	☐ Consistently followed up on referrals / recommendations ☐ Improved social support ☐ Is taking steps to increase social support ☐ Inconsistently followed up on referrals recommendations ☐ Reported interest in improving situation, but no change in behaviors ☐ Client was inconsistently interested in addressing ☐ No change ☐ Unknown
☐ **RISK FACTOR 13: DOMESTIC VIOLENCE** ☐ Not evident as a risk factor ☐ Not addressed due to: ☐ Client had other priorities ☐ Client declined to address ☐ Linked to DV services	☐ Consistently participating with DV services ☐ Safety of situation improved ☐ Client is considering obtaining DV services ☐ Reported interest in improving situation, but no change in behaviors ☐ Client was inconsistently interested in addressing ☐ No change ☐ Unknown
☐ **RISK FACTOR 14: CPS INVOLVEMENT** ☐ Not Applicable (Not evident) ☐ Not addressed due to: ☐ Client had other priorities ☐ Client declined to address ☐ Linked to CPS services ☐ Assisted in engaging with CPS Services	☐ Past CPS involvement (but not at onset of current MSS services) ☐ Current CPS involvement (at onset of current MSS Services) ☐ Improved situation ☐ CPS case closed ☐ Client consistently working to address ☐ Client was inconsistently interested in addressing ☐ No change ☐ Unknown
☐ **RISK FACTOR 15: COPING AND STRESS** ☐ Not evident as a risk factor ☐ Not addressed due to: ☐ Client had other priorities ☐ Client declined to address ☐ Assisted in obtaining appropriate services / or increasing coping skills	☐ Consistently followed up on referrals / recommendations ☐ Coping skills have improved ☐ Actively working to improve coping skills ☐ Reported interest in improving coping skills, but no change in behaviors ☐ Client was inconsistently interested in addressing ☐ No change ☐ Unknown
☐ **RISK FACTOR 16: HISTORY OF ABUSE** ☐ Not evident as a risk factor ☐ Not addressed due to: ☐ Client had other priorities ☐ Client declined to address ☐ Abuse issues explored ☐ Assisted with obtaining appropriate services	☐ Client received appropriate services ☐ Has plan for receiving services if necessary ☐ Reported interest in improving coping skills, but no change in behaviors ☐ Client was inconsistently interested in addressing ☐ Client chose not to address ☐ No change ☐ Unknown

Client Name: _____ Date of Birth: _____

OTHER FACTORS	OUTCOME INFORMATION
BIRTH/DELIVERY OUTCOMES ☐ Referred for developmental evaluation ☐ Referred to Birth to Three Program ☐ Referred to: _____	☐ Birth weight _____ ☐ Delivered (live birth) at 37 - 40 weeks gestation ☐ Delivered (live birth) at 34 - 36 weeks gestation ☐ Delivered (live birth) at 24 - 33 weeks gestation ☐ Miscarried at ___ weeks ☐ Stillbirth ☐ Unknown
CLIENT ICM ELIGIBILITY AND ICM SERVICE STATUS ☐ Referred for ICM	☐ Eligible for ICM ☐ Continued with ICM services ☐ Eligible for ICM, client declined services ☐ Ineligible for ICM, client wanted to continue services ☐ Unknown
SCHOOL STATUS OF SCHOOL-AGED CLIENTS ☐ Out of school at onset of services ☐ In school at onset of services	☐ Returned to school ☐ Seeking return to school ☐ Has plan for return to school ☐ Reported interest in returning to school, but no change in behaviors ☐ Remained out of school, no plan to return ☐ Unknown ☐ Stayed in school ☐ Left school ☐ Unknown

Discharge Comments *(optional)*:

Client satisfaction survey sent: ☐ Yes ☐ No

Staff Signature: _____ **Date:** _____

Client Name: _____ Date of Birth: _____

MSS INFANT SERVICE OUTCOME AND DISCHARGE SUMMARY

Client Name: _____

Date Discharged from MSS: _____

REASON FOR DISCHARGE FROM MSS:

☐ Client discontinued services ☐ No longer eligible
☐ Transferred to different agency ☐ Lost to follow-up
☐ Services completed ☐ Client moved
☐ Other:_____

AREA OF FOCUS AND INTERVENTION INFORMATION	CLIENT OUTCOME INFORMATION	All / Always	Some / Sometimes	None / Never	Unknown
NEWBORN INFANT HEALTH ☐ Assisted in obtaining primary care provider for infant	**Well child visits infant received:** *If answer is not all/always, check appropriate circle below:* ○ Parent reported intent, but did not consistently follow up ○ Parent declined ○ Other_____	☐	☐	☐	☐
	Immunizations infant received: *If answer is not all/always, check appropriate circle below:* ○ Parent reported intent, but did not consistently follow up ○ Parent declined ○ Other_____	☐	☐	☐	☐
	Recommended medical treatment infant received: *If answer is not all/always, check appropriate circle below:* ○ Not applicable ○ Parent reported intent, but did not consistently follow up ○ Parent declined ○ Other_____	☐	☐	☐	☐
	Parent appropriately cared for infant's oral health: *If answer is not all/always, check appropriate circle below:* ○ Parent reported intent, but did not consistently follow up ○ Parent declined ○ Other_____	☐	☐	☐	☐
	Parent protected infant from 2nd hand smoke exposure: *If answer is not all/always, check appropriate reason below:* ○ Not applicable ○ Parent reported intent, but did not consistently follow up ○ Parent declined ○ Other_____	☐	☐	☐	☐
	Parent knows signs of illness in infant: *If answer is not all/always, check appropriate circle below:* ○ Parent reported intent to learn, but didn't consistently wish to address ○ Parent declined ○ Topic not focused on due to other overwhelming priorities ○ Other_____	☐	☐	☐	☐

AREA OF FOCUS AND INTERVENTION INFORMATION	CLIENT OUTCOME INFORMATION	All / Always	Some / Sometimes	None / Never	Unknown
NUTRITION/FEEDING/GROWTH ☐ Assisted in obtaining appropriate nutrition services ☐ Referred to _____ for growth concerns	**Infant's growth was:** ○ **within** ○ **below** ○ **above standard guidelines.** **If growth was not within standard guidelines, parent followed up on recommendations:** *If answer is not all/always, check appropriate circle below:* ○ Parent reported intent, but did not consistently follow up ○ Parent declined ○ Other_____ **Feeding concerns were resolved:** *If answer is not all/always, check appropriate circle below:* ○ Not applicable ○ Parent reported intent, but did not consistently follow up ○ Parent declined ○ Other_____ **Infant is put to bed WITHOUT BOTTLE:** *If answer is not all/always, check appropriate circle below:* ○ Parent reported intent, but did not consistently follow up ○ Parent declined ○ Other_____	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐
DEVELOPMENT/ INFANT BEHAVIOR/BONDING ☐ Assisted in obtaining developmental evaluation ☐ Referred to _____ for assistance with bonding	**Development was appropriate for age.** ○ **yes** ○ **no** **If a developmental concern was identified, parent followed up on recommendations:** *If answer is not all/always, check appropriate circle below:* ○ Not applicable ○ Parent reported intent, but did not consistently follow up ○ Parent declined ○ Other_____ **Positive Mother/Baby bond was evident:** *If answer is not all/always, check appropriate circle below:* ○ Parent reported intent, but did not consistently follow up ○ Parent declined ○ Other_____ ☐ Infant was enrolled in Early Intervention Services	☐ ☐	☐ ☐	☐ ☐	☐ ☐

Client Name: _____ Date of Birth: _____

AREA OF FOCUS AND INTERVENTION INFORMATION	CLIENT OUTCOME INFORMATION	All / Always	Some / Sometimes	None / Never	Unknown
SAFETY ☐ Assisted in obtaining services/ safety products	**Parent reports using infant car seat:** *If answer is not all/always, check appropriate circle below:* ○ Parent reported intent, but did not consistently follow up ○ Parent declined ○ Other_____	☐	☐	☐	☐
	Parent reports putting infant on back to sleep: *If answer is not all/always, check appropriate circle below:* ○ Parent reported intent, but did not consistently follow up ○ Parent declined ○ Other_____	☐	☐	☐	☐
	Parent reports that pet safety is practiced: *If answer is not all/always, check appropriate circle below:* ○ Not applicable ○ Parent reported intent, but did not consistently follow up ○ Parent declined ○ Other_____	☐	☐	☐	☐
OTHER ☐ CPS report made ☐ _____	☐ CPS investigated and case not opened ☐ Infant was enrolled in CPS prevention services ☐ Infant was opened to CPS ☐ Infant was removed from parent's care ☐ Unknown				

ICM ENROLLMENT

☐ Infant was enrolled in ICM services
☐ Infant was not enrolled in ICM services due to:
☐ Ineligibility ☐ Client declined services ☐ Lost contact with client
☐ Mother wanted ICM services but was not eligible

Client satisfaction survey sent: ☐ Yes ☐ No

Discharge Comments *(optional)*:

_____

_____

_____

_____

_____

_____

Staff Signature: _____ **Date:** _____

Client Name: _____ Date of Birth: _____